California Advancing and Innovating Medi-Cal (CalAIM)
All Plan Letter (APL) Attachment 1
Mandatory Managed Care Enrollment (MMCE) Requirements

Attachment 1 provides additional policy and procedure guidance for Mandatory Managed Care Enrollment (MMCE) described in the CalAIM proposal and in the CalAIM All Plan Letter. The Attachment consists of sections that address MMCE impacted populations and beneficiary outreach and access.

I. Impacted Populations

1. The following populations will transition from Fee-For-Service (FFS) to Medi-Cal managed care no sooner than January 1, 2022:

    - Trafficking and Crime Victims Assistance Program, except Share of Cost (SOC) (non-dual and dual)
    - Individuals participating in accelerated enrollment (non-dual and dual)
    - Breast and Cervical Cancer Treatment Program (BCCTP) (non-dual)
    - Beneficiaries with Other Health Coverage (OHC) (non-dual)
    - Beneficiaries living in rural ZIP codes[1] (non-dual)

    Beneficiaries who are in counties operating under the County Organized Health System (COHS) plan model will be enrolled in a COHS Medi-Cal managed care health plan (MCP) effective no sooner than January 1, 2022.

    Beneficiaries in counties operating under other plan models (non-COHS) will be enrolled in an MCP between January 1, 2022, and February 1, 2022.

2. The following populations will transition from Medi-Cal managed care to FFS on January 1, 2022:

    - Omnibus Budget Reconciliations Act (OBRA) (non-dual and dual). This population was previously mandatorily enrolled in managed care in Napa, Solano, and Yolo counties.
    - SOC (non-dual and dual). Beneficiaries in COHS and Coordinated Care Initiative (CCI) counties, excluding institutional long-term care (LTC) SOC beneficiaries.

[1] Rural zip codes: 93558, 90704, 92225, 92226, 92239, 92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93562, 9359293555, 93556, 93560, 92252, 92256, 92268, 92277, 92278, 92284, 92285, 92286, 92304,92305, 92309, 92310, 92311, 92312, 92314, 92315, 92317, 92321, 92322, 92325, 92327, 92333, 92338, 92339, 92341, 92342, 92347, 92352, 92356, 92358, 92365, 92368, 92372, 92378, 92382, 92385, 92386, 92391, 92397, 92398

The beneficiaries' effective date for FFS will be January 1, 2022.

3. The following aid code groups will remain in FFS Medi-Cal as of January 1, 2022:

    - Restricted scope
    - Presumptive eligibility
    - State medical parole, county compassionate release, incarcerated individuals
    - Non-citizen pregnancy-related enrolled in Medi-Cal (not including Medi-Cal Access Infant Program enrollees)

4. Beneficiaries receiving pregnancy-related Medi-Cal services prior to January 1, 2022, will remain in their current delivery system through the end of the individual's postpartum period. New enrollments on January 1, 2022, and forward, will enroll into mandatory managed care.

5. For beneficiaries with OHC, Medi-Cal remains the payer of last resort.[2] As a result, DHCS will not assign a Primary Care Provider to beneficiaries with comprehensive OHC since their OHC holds primary risk for their health care services coverage.

6. Dually eligible beneficiaries (except those with SOC in the following aid code groups that currently receive benefits through the FFS delivery system), in non-COHS and non-CCI counties, will transition to Medi-Cal managed care no sooner than January 1, 2023:

    - Aged
    - Non-Disabled Adults (19+ years of age)
    - Non-Disabled Children (<19 years of age)
    - Breast and Cervical Cancer Treatment Program (BCCTP)
    - Disabled

    Additionally, all beneficiaries enrolled in Home and Community Based Waivers, will be mandatorily enrolled in Medi-Cal managed care statewide starting no sooner than January 1, 2023.

7. Non-Dual and Dual beneficiaries in LTC, including LTC SOC, who currently receive benefits through the FFS delivery system in non-COHS and non-CCI counties will transition to Medi-Cal managed care no sooner than January 1, 2023.

8. The following populations will be excluded from MMCE:

[2] Welfare & Institutions Code (WIC) section 14124.90. WIC is searchable at: https://leginfo.legislature.ca.gov/

The Department of Health Care Services (DHCS) will not change enrollment requirements for foster care children and youth at this time. American Indian/Alaska Native beneficiaries will have the option to opt in or opt out of managed care enrollment in non-COHS counties using the non-medical exemption form (HCO 7102).

Beneficiaries who reside in a California Veteran Home will be exempt from MMCE. Beneficiaries enrolled in the Program of All-Inclusive Care for the Elderly (PACE) or SCAN Health Plan will be excluded from MMCE.

II. Beneficiary Outreach and Access

1. DHCS will send notices to all beneficiaries who will be transitioning on January 1, 2022, per the following timelines:

    - Beneficiaries transitioning from Medi-Cal managed care to FFS Medi-Cal will receive a 60-day notice no later than mid-October 2021, and a 30-day notice no later than mid-November 2021.
    - Beneficiaries transitioning from FFS Medi-Cal to Medi-Cal managed care will receive a 90-day notice for beneficiaries who are enrolled in Cal MediConnect Plans by October 4, 2021, a 60-day notice no later than mid-October 2021, and a 30-day notice no later than mid-November 2021.

    DHCS will mail “Choice Packets” which explain MCP options in the beneficiaries’ county and explain MCP selection processes, by November 30, 2021, to beneficiaries who are transitioning to Medi-Cal managed care.

    DHCS is developing a notification plan for beneficiaries impacted by MMCE effective January 1, 2023 and will provide more details on the notification plan in the future.

2. Beneficiaries already voluntarily enrolled in an MCP in a non-COHS county for more than 90 days will not qualify to file a Medical Exemption Request (MER) due to mandatory enrollment because they are not transitioning into Medi-Cal managed care. A MER is an available option to beneficiaries when transitioning from FFS Medi-Cal to Medi-Cal managed care, and may be filed within 90 days of enrollment in an MCP.

3. Network readiness should reflect MCP’s enrollment changes and populations shifts resulting from MMCE implementation and will vary for MCPs. MCPs that will expand membership in rural areas as a result of MMCE will be required to submit Accessibility Analyses to demonstrate compliance with time and distance standards, and applicable Alternative Access Standard requests if the MCP is unable to meet time and distance standards, which are outlined in APL 21-006, Network Certification Requirements, or any superseding APL. MCPs will also be required to meet provider-to-member ratios to demonstrate an adequate network to serve the

new populations transitioning into Medi-Cal managed care. APLs can be found on the DHCS website here: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

4. Consistent with APL 18-008, Continuity of Care (COC) for Medi-Cal beneficiaries who transition into Medi-Cal managed care, and DPL 16-002 COC, or any superseding APL or DPL, MCPs are required to follow the current process to approve COC for beneficiaries who request it.